Term	Definition
270	A HIPAA Transaction that is sent in inquire about a recipient/subscriber/client's eligilbity status.
271	A HIPAA transaction that is sent in response to a 270 that contains eligiblity status information for a recipient/subscriber/client.
835	A HIPAA transaction that is sent in response to an 837 and contains remittance information about claims submitted for rendered services.
837	A HIPAA transaction, that includes claim information for the purpose of reimbursment for a rendered service. - There are 3 variations of 837 Transactions: **Initial** - Initial Claim for Services **VOID** - To 'Void' a previously approved (paid) claim. Takes the place of the DCS System for Phase I claims. **Replacement** - To replace a previously Approved or Denied Claim
997	Functional Acknowledgement of the 837. Can either be **Accepted** in which case an 835 is forthcoming or **Rejected** in which case the County must re-submit the claim file once the issues causing the rejection have been addressed.
Bed	The Bed is the most precise location of a patient.
Benefit Plan	The basic defined plan and level of coverage for each guarantor. The plan contains the Billing Categories which direct the system to the appropriate Service codes covered by the plan. Since all plans are associated to the patient's guarantor, the system is able to establish whether the guarantor will pay for the service code.
Client ID	Medical record number assigned to a client during admission to a program. Clients that were active in the legacy CATS system will retain their CATS IDs and this will remain their client ID.
Close Charges	Closing charges prevents any service fee changes to existing posted services due to changes in the service code fee, guarantor definition or benefit plan definition.
CSI	Acronym for manadated State reporting (Client Service Information)
Delay Reasons	Codes that indicate the reason that a specified service is being submitted for reimbursment outside the window for normal timlieness requirements.
Dictionary	A dictionary is a list of acceptable responses associated with a dictionary data element. In a data element, the list displays as a drop-down menu (normally unlocked) or a series of buttons (locked). A "locked" dictionary cannot be modified.
Episode	An episode consists of all of the services that were provided to a client in all of the programs between admission and discharge. A client can be admited in multiple episodes simultaneously. A maximum of one Inpatient/Residential and/or Partial Hospitalization episode may be concurrent with other active episodes. There is no restriction on the number of active Outpatient episodes. This is determined by the treatment setting assigned to the Program the client was admitted to.
Financial Class	This dictionary is utilized throughout the software to allow the user to logically group guarantors. The software groups guarantors under these categories for both billing reports as well as bill generation logic.
GAF	Global Assessment Functioning- The GAF is a 1 to 100 scale used in Axis V diagnosis
Guarantor	The term guarantor is used to identify any expected source of reimbursement for services provided to a client. Guarantor can include self pay, third party private insurance, and or entitlements such as Medicaid or Medicare.
ICD9 Diagnosis Code	An ICD9 code is from the International Classification of Diseases.
Modifiers	Codes used to supply additional information about the claim (e.g. duplicate service modifiers).
Option	Screen or Form in AVATAR
OSHPD	Office of State Hospital Planning and Development.

Payer Claim Control Number (PCCN)	The unique Id number for the claim in the state's adjudication system.
Post Residential WorkList	Posting the worklist sends the room and board charges to the client ledgers for the purpose of billing.
Pre-display	A pre-display is a screen that displays upon option entry for those options that have historic grouping data elements and clients that have existing records in that option. The pre-display shows all of the existing records for the selected client.
Provider Start Date	The date of the first face-to-face service with a client at a particular program.
Required Field	A required field is a data element within an option that must be completed in order to file the data.
Service Code	A code to track all billable and non-billable patient or provider activities (events). This value is also referred to as a charge code.
System Code	The environment or instance of the application, determines the breadth of data a user has access to.
Unit Census	The unit census is a list of all of the clients with bed assignments minus all clients on unchargable leave.